

MINNESOTA DEPARTMENT OF HEALTH  
Section of Vital Statistics  
CERTIFICATE OF DEATH

1 2291015841

STATE FILE NUMBER

LOCAL FILE NUMBER

02036

1. DECEDENT'S NAME (Print) <b>RICHARD ARCHIE HELWIG</b>		2. SEX <b>MALE</b>	3. DATE OF DEATH (month, day, year) <b>JUNE 16, 1991</b>	4. TIME OF DEATH <b>0710</b>
5. SOCIAL SECURITY NUMBER <b>524-44-4319</b>	6a. AGE Last Birthday (years) <b>55</b>	6b. UNDER 1 YEAR months days hours minutes	7. DATE OF BIRTH (month, day, year) <b>November 6, 1935</b>	
8. BIRTHPLACE (city and state or foreign country) <b>Minneapolis, Minnesota</b>	9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no) <b>Yes</b>	10a. PLACE OF DEATH (check only one - see instructions on other side) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OTHER (specify) <b>Fed. Med. Ctr.</b>		<input type="checkbox"/> Nursing home <input type="checkbox"/> Residence
10b. FACILITY NAME (if not institution, give street and number) <b>2110 East Center Street</b>	10c. CITY OR TOWNSHIP OF DEATH <b>Rochester</b>	10d. COUNTY OF DEATH <b>Olmsted</b>		
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (specify) <b>Never Married</b>	12. SPOUSE - Name (if wife, give maiden name)	13a. DECEDENT'S USUAL OCCUPATION (give kind of work done during most of working life. Do not use retired) <b>Bookkeeper</b>		
13b. KIND OF BUSINESS/INDUSTRY <b>Bookkeeping</b>	14a. RESIDENCE - State <b>Minnesota</b>	14b. COUNTY <b>Olmsted</b>	14c. CITY OR TOWNSHIP <b>Rochester</b>	
14d. STREET AND NUMBER <b>2110 East Center Street</b>	14e. INSIDE CITY LIMITS? (specify yes or no) <b>Yes</b>	14f. ZIP CODE <b>55904</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? (specify yes or no - if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
16. RACE (see instructions on other side) <b>White</b>	17. DECEDENT'S EDUCATION (specify only highest grade completed) Elementary/Secondary (0-12) College (13-16 or 17+) <b>12</b>	18. FATHER'S NAME (first, middle, last) <b>Archie Helwig</b>		
19. MOTHER'S NAME (first, middle, maiden surname) <b>Ethel</b>	20. INFORMANT'S NAME (Type/print) <b>Federal Medical Center Records</b>		20b. INFORMANT'S MAILING ADDRESS Street and Number or Rural Route Number, City, State, Zip Code <b>2110 East Center Street Rochester, MN 55904</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from state <input type="checkbox"/> Donation <input type="checkbox"/> Other (specify)	21b. LOCATION - City or Township, State <b>Rochester, Minnesota</b>		21c. SIGNATURE OF FUNERAL DIRECTOR OR MINISTER <i>[Signature]</i>	
21d. PLACE OF DISPOSITION Name of cemetery, crematory, or other place <b>Oakwood Cemetery</b>	22. NAME AND ADDRESS OF FUNERAL ESTABLISHMENT <b>Macken Funeral Home 1105 12th St. S.E. Rochester, Minnesota 55904</b>		23a. CERTIFICATION PHYSICIAN I attended the deceased from ____ mo. ____ day ____ year to ____ mo. ____ day ____ year and last saw him/her on ____ mo. ____ day ____ year I (did/did not) view the body after death.	
23b. LICENSE NUMBER (of Funeral Establishment) <b>0228</b>	23c. SIGNATURE Physician, Medical Examiner, or Coroner <i>[Signature]</i>	23d. LICENSE NUMBER (of physician) <b>14207</b>	23e. DATE SIGNED (month, day, year) <b>6/17/91</b>	24. REGISTRAR'S SIGNATURE <i>[Signature]</i>
25. NAME AND ADDRESS OF PHYSICIAN <input checked="" type="checkbox"/> MEDICAL EXAMINER OR CORONER <b>Paul G. Belau, M.D., Coroner Law Enforcement Center Rochester, MN 55903</b>		26. DATE SIGNED (month, day, year) <b>6-21-91</b>		
26. CAUSE OF DEATH PART I Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b> due to or as a consequence of: <b>Acquired immunodeficiency syndrome (AIDS)</b> due to or as a consequence of:		27. IF DIAGNOSIS DEFERRED Check box <input type="checkbox"/>		Approximate interval between onset and death
IMMEDIATE CAUSE (final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST		28. PART II OTHER SIGNIFICANT CONDITIONS contributing to death but not resulting in the underlying cause given in PART I		
29. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		29a. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	29b. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	29c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
30. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	31a. DATE OF INJURY (month, day, year)		31b. TIME OF INJURY	
31c. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)		31d. LOCATION - (street and number) city or township, state		

HE-00110-04 REV. (1/89)

See other side for instructions on completing cause of death and other important items.

Type/Print in Permanent Black Ink For Instructions See Other Side

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